CHAPTER V. AMBULATORY SURGERY

This section of the report presents information about ambulatory surgery collected from hospital-based ambulatory surgery programs and freestanding ambulatory surgery centers (FASCs).

Facilities that Reported Data

BHI collected ambulatory surgery data from 124 general medical-surgical hospitals and 33 FASCs during 2002. They submitted records on 737,288 patients (630,167 at hospitals and 107,121 at FASCs).

FASC Openings/Medicare Certification

Woodland Surgery Center, Appleton, January, 2002

Marshfield Clinic Eau Claire Ambulatory Surgery Center, January, 2002

Arthroscopic & Ambulatory Surgery Center, Appleton, Fourth Quarter, 2002

Rhinelander Regional Medical Group ASC, Fourth Quarter, 2002

Milwaukee Endoscopy Center, Fourth Quarter, 2002

Madison Laser Eye Center, Fourth Quarter, 2002

Marshfield Clinic Wausau Center Ambulatory Surgery Center, Fourth Quarter, 2002

Special Circumstances

Mercy Walworth Ambulatory Surgery Center, Lake Geneva, data is now submitted together with the data from Mercy Hospital, Janesville

Hand Doctors of Milwaukee was never Medicare certified and therefore has no obligation to submit data to BHI

GMS Hospitals

For openings, closings, and special circumstances for GMS hospitals, see the table on page 35.

Selected Data Reported by Wisconsin Hospitals and FASCs

BHI collects data on all ambulatory surgery procedures performed in hospital-based outpatient surgery units and Medicare-certified FASCs. However, a significant number of ambulatory surgeries performed in Wisconsin are not included in BHI's database. This is because ambulatory surgeries are also performed in settings which are not required to submit data to BHI, such as FASCs that are not Medicare-certified, and clinics and urgent care centers that are not owned and operated by hospitals.

Charges in these reports represent the average amount billed for a surgical episode and are not necessarily the facility's routine charge for a particular type of surgery. Each record BHI collects contains a code for the principal procedure (the reason for the surgery) and codes for up to five other procedures. A patient who had multiple procedures should expect to have higher charges than one who had only one procedure.

The 20 procedures for which individual facility data are presented in this report are those principal procedures that were most frequently reported in 2001.

CPT-4 Codes vs. ICD-9-CM Codes

Hospitals and FASCs typically use different coding systems to report data to BHI. FASCs generally use CPT-4 procedure codes. Hospitals tend to use ICD-9-CM codes, although they may also use CPT-4 codes for Medicare patients, such as those undergoing cataract surgery.

The two coding systems are similar but not identical. For example, under CPT-4 coding, cataract removal and lens insertion can be reported as a single code; under ICD-9-CM coding, each step of the surgery must be reported as a separate code.

In order to present information on hospitals and FASCs together, it is necessary to convert the data into one common set of procedure codes. To do this, BHI uses computer software expressly designed to convert CPT-4 codes to ICD-9-CM codes.

How to Read The Ambulatory Surgery Tables

Summary Tables

The first part of the ambulatory surgery section presents data in the following summary tables:

- Table 25 presents the number of cases, the average charge and the quartile charges for 20 selected procedures (selected because they were the most frequently reported during 2001 by hospitals and FASCs in Wisconsin).
- Table 26 presents the age and sex distributions for patients undergoing these 20 procedures.
- Table 27 shows the expected primary pay sources for patients undergoing these 20 procedures.
- Tables 28-30 present the ICD-9-CM codes, number of cases, average charge, and total charges generated by the 40 most frequently reported ambulatory procedures, the 20 most expensive procedures (for which at least 5 cases were reported), and the 20 procedures generating the greatest amounts in overall charges during all of 2002.
- Table 31 sorts all the ambulatory procedures reported to BHI during 2002 into categories that describe the part of the body or system on which they were performed. The category Diagnostic/Therapeutic contains miscellaneous procedures not assigned to any of the other categories.

Comparison Group Tables

For each of the 20 selected surgical procedures, there is a table showing the number of cases, average charge per case, standard deviation, and the 25th, 50th, 60th, 70th, 75th, 80th, 85th, 90th, and 95th percentile distribution of charges statewide for all facilities, statewide for hospitals only, and statewide for FASCs only. The same data elements are presented for each three-digit ZIP code area in the state with hospital and FASC data combined. (See graphic on page 337.)

Facility-Specific Tables

For each procedure a table shows, by facility, the number of cases, average charge per case, standard deviation, and median charge. Data are sorted by three-digit ZIP code area and by city within each area. Hospitals and FASCs appear on the same tables, with an "H" designating a Hospital and an "F" a FASC. (See graphic on page 338.)

Facilities that reported fewer than three cases of a given procedure do not appear in the table for that procedure. However, their data are included in the statewide and ZIP code area totals. Facilities that reported three or four cases for a given procedure do appear in the table for that procedure; however, charge data are not provided, due to the small number of cases.

Comparison Group Tables

# of Cases is the number of cases for which this procedure was listed as the principal procedure.

Average Charge is calculated by totaling the charges for all patients assigned to the surgical category and dividing by the number of cases. It represents the amount, on average, a patient undergoing this type of ambulatory surgery was charged.

Standard Deviation is a measure of the average variation above or below the mean, or average, charge. When charges are in a normal distribution, approximately 68 percent of the cases will fall within one standard deviation of the mean, 95 percent within two standard deviations, and 99.7 percent within three standard deviations.

Percentile Charges mark the point above and below which some percentage of the patients' charges fall. For instance, half the patients were charged less than the 50th percentile, or median charge, and half were charged more. Similarly, 95 percent were charged less than the 95th percentile, and 5 percent were charged more.

ICD-9-CM Code 45.25: Endoscopic Biopsy of Large Intestine

January – December 2002

Note: Utilization and charge data are per surgical episode. They may include procedures other than the principal procedure.

	# OF CASES	AVERAGE CHARGE	STANDARD DEVIATION	PERCENTILE CHARGES								
				25TH	*50TH*	*60TH*	*70TH*	*75TH*	*80TH*	*85TH*	*90TH*	*95TH*
STATEWIDE DATA												
All Facilities	19,563	$1,751	$872	$1,151	$1,559	$1,770	$1,992	$2,155	$2,329	$2,548	$2,834	$3,356
FASCs	3,722	1,254	450	921	1,155	1,213	1,405	1,500	1,500	1,656	1,820	1,956
Hospitals	15,841	1,868	906	1,257	1,695	1,902	2,156	2,303	2,476	2,666	3,016	3,481
3 DIGIT ZIP CODE AREA DATA												
530**	2,399	$1,830	$751	$1,109	$1,705	$1,907	$2,170	$2,369	$2,469	$2,586	$2,735	$3,068
531**	1,516	1,972	833	1,593	1,822	1,939	2,030	2,105	2,336	2,581	2,948	3,723
532**	2,080	2,244	1,118	1,500	2,221	2,411	2,656	2,849	3,127	3,289	3,528	4,037
534**								2,459	2,925	3,142	3,340	3,964
535**								1,925	2,040	2,146	2,335	2,652
537**								1,522	1,568	1,668	1,911	2,223
538**								2,945	3,007	3,098	3,210	3,671
539**								2,026	2,160	2,298	2,470	2,832
540**	328	1,507	527	1,227	1,448	1,542	1,782	1,800	1,813	1,857	1,887	2,163
541**	284	1,339	360	1,124	1,304	1,329	1,400	1,425	1,476	1,548	1,616	1,715

The number of cases and the distribution of charges are summarized for the entire state and for each three-digit ZIP code area in the state. These figures include both hospitals and FASCs. Statewide data are also presented for hospitals only, and for FASCs only.

Facility-Specific Tables

ICD-9-CM Code (International Classification of Diseases, 9th Revision, Clinical Modification) is a coding system used by facilities, on patient records and billing forms, to designate which surgical procedure(s) were performed.

# of Cases is the number of cases at the facility for which this ICD-9-CM code was listed as the principal procedure. Facilities reporting fewer than three cases do not appear in the tables, although their data are included in the statewide and three-digit ZIP code area data. Facilities that reported three or four discharges do appear in the tables, but no charge data are presented for those cases.

Average (Mean) Charge is calculated by totaling the charges for all cases with this principal procedure and dividing by the number of cases. It represents the amount, on average, a patient assigned to this surgical category was charged.

Median Charge is the amount that half the patients were charged more than and half were charged less than.

Standard Deviation is a measure of the average variation above or below the average, or mean, charge. When charges are in a normal distribution, approximately 68 percent of the cases will fall within one standard deviation of the mean, 95 percent within two standard deviations, and 99.7 percent within three standard deviations.

ICD-9-CM Code 45.25: Endoscopic Biopsy of Large Intestine

January - December 2002

Note: Utilization and charge data are per surgical episode. They may include procedures other than the principal procedure.

BY FACILITY WITHIN 3 DIGIT ZIP CODE AREAS
(Excludes facilities with fewer than 3 cases)

Facilities are sorted by three-digit ZIP code area. Within each area, Facilities are sorted alphabetically by city. An "H" indicates the facility is a hospital; an "F" designates a FASC.

		TYPE OF FACILITY	# OF CASES	AVERAGE CHARGE	MEDIAN CHARGE	STANDARD DEVIATION
530						
Elmbrook Memorial Hospital	Brookfield	H	260	$1,822	$1,729	$546
Calumet Medical Center, Inc.	Chilton	H	91	2,443	2,536	534
Aurora Medical Center	Hartford	H	99	2,863	2,779	438
Community Memorial Hospital	Menomonee Falls	H	100	1,987	1,905	397
Menomonee Falls Amb. Surgery Center	Menomonee Falls	F	634	1,122	1,109	144
St. Mary's Hospital-Ozaukee	Mequon	H	372	2,618	2,473	828
Oconomowoc Memorial Hospital	Oconomowoc	H	162	1,912	1,866	569
Sheboyga		H	222	1,753	1,529	543
St. Nichol		H	185	1,789	1,681	447
Watertow		H	64	1,854	1,984	476
St. Josept		H	49	2,579	2,533	600
West Ben		F	161	1,571	1,405	429
531						
Memorial Hospital Corp. of Burlington	Burlington	H	150	2,083	2,016	336
Aurora Lakeland Medical Center	Elkhorn	H	90	2,845	2,500	909
Aurora Medical Center - Kenosha	Kenosha	H	199	3,168	2,932	1,115
Children's Hospital of Wisconsin, Inc. -	Kenosha	H	6	3,071	2,854	509
United Hospital System - Kenosha Medical	Kenosha	H	361	1,337	1,184	478
Aurora Ambulatory Surgery	Waukesha	F	84	1,883	1,956	371
Waukesha Memorial Hospital, Inc.	Waukesha	H	626	1,806	1,757	390
532						
Milwaukee Endoscopy Center	Greenfield	F	96	871	879	54
Wisconsin Health Center, LLC	Greenfield	F	12	1,300	1,300	0

Table 25. Summary of selected ambulatory surgical procedure data, Wisconsin GMS hospitals and FASCs, 2002

ICD-9-CM Code	Procedure	Number of Cases	Avg. Charge	Percentile Distribution of Charges 25th	50th	75th
03.91	Injection of Spinal Canal for Analgesia	19,306	$816	$535	$723	$978
03.92	Injection of other Agent into Spinal Canal	28,863	833	612	781	1,015
04.43	Carpal Tunnel Release	11,488	2,480	1,542	2,213	2,946
13.41	Phacoemulsification and Aspiration of Cataract	32,412	3,680	2,682	3,550	4,464
13.59	Other Extracapsular Extraction of Lens	12,492	3,094	2,711	2,711	3,439
20.01	Myringotomy with Insertion of Tube	11,785	1,986	1,351	1,600	2,408
28.3	Tonsillectomy with Adenoidectomy	7,670	3,058	2,284	2,842	3,624
37.22	Left Heart Cardiac Catheterization	12,919	6,656	4,990	6,284	7,880
42.92	Dilation of Esophagus	7,096	1,585	1,073	1,405	1,871
45.13	Other Endoscopy of Small Intestine	14,658	1,288	816	1,090	1,484
45.16	EGD† w/Closed Biopsy	40,148	1,710	1,083	1,473	2,052
45.23	Colonoscopy	61,958	1,354	943	1,214	1,615
45.24	Flexible Sigmoidoscopy	7,041	702	315	491	886
45.25	Endoscopic Biopsy of Large Intestine	19,563	1,751	1,151	1,559	2,155
45.42	Endoscopic Polypectomy of Large Intestine	43,416	1,843	1,223	1,702	2,266
51.23	Laparoscopic Cholecystectomy	9,702	7,292	5,115	7,126	8,919
57.32	Other Cystoscopy	10,186	1,714	734	1,137	2,246
80.6	Excision of Semilunar Cartilage of Knee	14,684	4,884	3,263	4,351	5,729
85.21	Local Excision of Lesion of Breast	8,851	3,710	2,110	3,029	4,475
86.3	Local Excision/Destruction of Lesion or Tissue of Skin	20,468	1,260	217	550	1,773

Note: Charges may reflect charges for other ambulatory procedures performed during the same surgical episode. Refer to page 337 for an explanation of percentiles.

† Esophagogastroduodenoscopy

Source: Ambulatory Surgery Data, Bureau of Health Information, Division of Health Care Financing, Department of Health and Family Services.

Table 26. Age and sex distribution of persons undergoing selected ambulatory procedures, Wisconsin GMS hospitals and FASCs, 2002

ICD-9-CM Code	Procedure	Age Groupings 0-14	15-44	45-64	65+	Sex Male	Female
03.91	Injection of Spinal Canal for Analgesia	0.0%	28.3%	36.2%	35.4%	42.7%	57.3%
03.92	Injection of other Agent into Spinal Canal	0.1	28.7	35.7	35.4	43.1	56.9
04.43	Carpal Tunnel Release	0.0	32.4	41.4	26.2	37.2	62.8
13.41	Phacoemulsification and Aspiration of Cataract	0.1	1.5	15.8	82.6	37.6	62.4
13.59	Other Extracapsular Extraction of Lens	0.2	1.7	16.0	82.1	38.0	62.0
20.01	Myringotomy with Insertion of Tube	91.4	3.4	2.1	3.1	57.9	42.1
28.3	Tonsillectomy with Adenoidectomy	91.5	8.4	0.1	0.0	47.7	52.3
37.22	Left Heart Cardiac Catheterization	0.0	8.5	48.6	42.9	58.2	41.8
42.92	Dilation of Esophagus	0.4	18.7	35.0	45.9	50.9	49.1
45.13	Other Endoscopy of Small Intestine	0.8	31.2	36.0	32.0	39.4	60.6
45.16	EGD† with Closed Biopsy	3.3	27.9	38.2	30.6	44.3	55.7
45.23	Colonoscopy	0.1	13.3	51.8	34.8	41.2	58.8
45.24	Flexible Sigmoidoscopy	0.3	17.8	49.9	32.0	47.0	53.0
45.25	Endoscopic Biopsy of Large Intestine	1.7	30.8	39.8	27.8	40.0	60.0
45.42	Endoscopic Polypectomy of Large Intestine	0.1	6.9	49.3	43.7	54.9	45.1
51.23	Laparoscopic Cholecystectomy	0.3	49.2	36.5	14.0	21.2	78.8
57.32	Other Cystoscopy	1.4	17.8	30.3	50.4	58.5	41.5
80.6	Excision of Semilunar Cartilage of Knee	0.6	34.3	50.6	14.5	58.2	41.8
85.21	Local Excision of Lesion of Breast	0.4	32.4	43.7	23.6	3.3	96.7
86.3	Local Excision/Destruction of Lesion or Tissue of Skin	8.2	33.9	31.2	26.6	45.4	54.6

Note: Rows may not total 100% due to rounding.

† Esophagogastroduodenoscopy

Source: Ambulatory Surgery Data, Bureau of Health Information, Division of Health Care Financing, Department of Health and Family Services.

Table 27. Expected primary pay source distribution of persons undergoing selected ambulatory procedures, Wisconsin GMS hospitals and FASCs, 2002

ICD-9-CM Code	Procedure	T18	T19	Other Gov't	Commercial Insurance	Self-Pay	Unknown
03.91	Injection of Spinal Canal for Analgesia	37.2%	4.4%	1.0%	56.5%	0.9%	0.0%
03.92	Injection of other Agent into Spinal Canal	37.0	3.5	0.4	58.2	0.9	0.0
04.43	Carpal Tunnel Release	27.0	4.5	0.5	66.9	0.9	0.1
13.41	Phacoemulsification and Aspiration of Cataract	81.4	1.0	0.3	16.8	0.5	0.1
13.59	Other Extracapsular Extraction of Lens	76.6	1.4	0.1	21.5	0.4	0.0
20.01	Myringotomy with Insertion of Tube	2.1	17.7	0.4	78.6	1.1	0.1
28.3	Tonsillectomy with Adenoidectomy	0.0	15.3	0.7	82.8	1.1	0.1
37.22	Left Heart Cardiac Catheterization	43.6	2.8	1.0	51.5	1.1	0.0
42.92	Dilation of Esophagus	47.0	2.2	0.2	49.7	0.8	0.0
45.13	Other Endoscopy of Small Intestine	34.4	4.7	1.2	58.1	1.5	0.0
45.16	Esophagogastroduodenoscopy (EGD) w/Closed Biopsy	32.0	4.7	0.7	61.4	1.1	0.1
45.23	Colonoscopy	34.6	1.8	0.7	62.2	0.7	0.1
45.24	Flexible Sigmoidoscopy	32.5	2.6	1.3	62.5	1.0	0.1
45.25	Endoscopic Biopsy of Large Intestine	28.5	3.4	0.8	66.1	1.2	0.1
45.42	Endoscopic Polypectomy of Large Intestine	42.4	1.4	0.7	54.9	0.6	0.1
51.23	Laparoscopic Cholecystectomy	14.9	6.9	0.8	75.0	2.3	0.1
57.32	Other Cystoscopy	51.1	3.9	1.3	42.9	0.8	0.0
80.6	Excision of Semilunar Cartilage of Knee	14.5	2.3	0.5	81.6	1.0	0.1
85.21	Local Excision of Lesion of Breast	24.6	4.2	1.2	68.3	1.5	0.1
86.3	Local Excision/Destruction of Lesion or Tissue of Skin	26.8	4.2	1.0	66.5	1.4	0.1

Note: Rows may not total 100% due to rounding.

T18 refers to Medicare. T19 refers to Medical Assistance.

Source: Ambulatory Surgery Data, Bureau of Health Information, Division of Health Care Financing, Department of Health and Family Services.

Table 28. Most frequently performed ambulatory surgical procedures, Wisconsin GMS hospitals and FASCs, 2002

ICD-9-CM Code	Procedure	Number of Cases	Average Charge	Total Charges
45.23	Colonoscopy	61,958	$1,354	$83,912,637
45.42	Endoscopic Polypectomy of Large Intestine	43,416	1,843	80,027,215
45.16	Esophagogastroduodenoscopy (EGD) w/Closed Biopsy	40,148	1,710	68,659,578
13.41	Phacoemulsification and Aspiration of Cataract	32,412	3,680	119,287,153
03.92	Injection of other Agent into Spinal Canal	28,863	833	24,049,957
86.3	Local Excision/Destruction of Lesion or Tissue of Skin	20,468	1,260	25,799,540
45.25	Endoscopic Biopsy of Large Intestine	19,563	1,751	34,262,383
03.91	Injection of Spinal Canal for Analgesia	19,306	816	15,751,823
80.6	Excision of Semilunar Cartilage of Knee	14,684	4,884	71,723,202
45.13	Other Endoscopy of Small Intestine	14,658	1,288	18,879,561
37.22	Left Heart Cardiac Catheterization	12,919	6,656	85,986,095
13.59	Other Extracapsular Extraction of Lens	12,492	3,094	38,652,950
20.01	Myringotomy with Insertion of Tube	11,785	1,986	23,410,491
04.43	Carpal Tunnel Release	11,488	2,480	28,495,970
57.32	Other Cystoscopy	10,186	1,714	17,455,535
51.23	Laparoscopic Cholecystectomy	9,702	7,292	70,750,462
85.21	Local Excision of Lesion of Breast	8,851	3,710	32,833,074
28.3	Tonsillectomy with Adenoidectomy	7,670	3,058	23,451,756
45.43	Endoscopic Destruction of Lesion/Tissue of Large Intestine	7,369	1,480	10,907,233
42.92	Dilation of Esophagus	7,096	1,585	11,243,969
45.24	Flexible Sigmoidoscopy	7,041	702	4,941,206
85.11	Closed (Percutaneous)(Needle) Breast Biopsy	6,953	1,919	13,341,672
04.81	Injection of Anesthetic into Peripheral Nerve for Analgesia	6,842	1,290	8,824,600
81.92	Injection of Therapeutic Substance into Joint or Ligament	6,226	674	4,195,009
13.64	Discission of Secondary Membrane After Cataract	6,175	1,011	6,244,999
48.36	Endoscopic Polypectomy of Rectum	5,976	1,763	10,538,635
81.83	Other Repair of Shoulder	3,928	7,091	27,855,330
28.2	Tonsillectomy without Adenoidectomy	3,847	3,354	12,904,627
77.51	Bunionectomy with Osteotomy of the First Metatarsal	3,735	4,824	18,018,578
69.09	Other Dilation and Curettage (D&C)	3,659	4,015	14,691,746
86.24	Chemosurgery of Skin	3,594	582	2,091,596
83.63	Rotator Cuff Repair	3,409	8,002	27,279,922
66.29	Bilateral Endoscopic Destr./Occlusion of Fallopian Tubes	3,397	4,082	13,866,577
53.04	Repair of Indirect Inguinal Hernia w/Graft or Prosthesis	3,277	4,951	16,223,736
50.11	Closed Percutaneous (Needle) Biopsy of Liver	2,934	1,959	5,748,464
57.49	Oth. Transurethral Excision/Destr. Lesion/Tissue of Bladder	2,822	4,015	11,329,003
82.21	Excision of Lesion of Tendon Sheath of Hand	2,802	2,766	7,751,448
75.35	Other Diagnostic Procedures on Fetus and Amnion	2,767	429	1,185,671
53.03	Repair of Direct Inguinal Hernia with Graft or Prosthesis	2,675	4,877	13,045,680
53.49	Other Umbilical Herniorrhaphy	2,628	3,543	9,310,381

Note: Charges may reflect charges for other procedures performed during the same surgical episode.

Source: Ambulatory Surgery Data, Bureau of Health Information, Division of Health Care Financing, Department of Health and Family Services.

Table 29. Most expensive ambulatory surgical procedures (with at least 5 cases reported), Wisconsin GMS hospitals and FASCs, 2002

ICD-9-CM Code	Procedure	Number of Cases	Average Charge	Total Charges
37.94	Implant/Repl. Auto. Cardioverter/Defibrillator, Total Sys. (AICD)	93	$54,430	$5,061,955
20.98	Implant/Replace Cochlear Prosthetic Device, Multiple Channel	10	43,538	435,384
37.96	Implantation Auto. Cardioverter/Defibrillator Pulse Generator Only	9	40,501	364,505
92.30	Stereotactic Radiosurgery, Not Otherwise Specified	39	36,469	1,422,289
37.98	Replace Automatic Cardioverter/Defibrillator Pulse Generator Only	209	35,649	7,450,561
20.96	Implant/Repl. Cochlear Prosthetic Device, Not Otherwise Specified	66	35,515	2,343,980
36.05	Multiple Vessel PTCA† w/wo/Mention of Thrombolytic Agent	180	26,609	4,789,586
37.83	Initial Insertion of Pacemaker with Dual-Chamber Device	174	25,044	4,357,675
02.93	Implantation of Intracranial Neurostimulator	35	23,397	818,884
36.02	1 Vessel PTCA† or Coronary Atherectomy w/Thrombolytic Agent	23	22,901	526,723
37.82	Initial Insertion of a Single-Chamber Device, Rate Responsive	19	22,565	428,730
37.89	Revision or Removal of Pacemaker Device	18	22,129	398,326
04.92	Implantation or Replacement of Peripheral Neurostimulator	160	21,483	3,437,234
35.52	Repair of Atrial Septal Defect with Prosthesis, Closed Technique	6	21,426	128,556
37.81	Initial Insert. 1-Chamber Device not Specified as Rate Responsive	34	20,407	693,853
37.34	Catheter Ablation of Lesion or Tissue of Heart	554	20,270	11,229,567
37.72	Initial Insertion of Transvenous Leads into Atrium and Ventricle	70	20,041	1,402,887
44.39	Other Gastroenterostomy	6	19,797	118,780
37.71	Initial Insertion of Transvenous Leads into Ventricle	35	19,539	683,861
81.80	Total Shoulder Replacement	5	19,157	95,787

Note: Charges may reflect charges for other procedures performed during the same surgical episode

†PTCA: Percutaneous Transluminal Coronary Angioplasty

Source: Ambulatory Surgery Data, Bureau of Health Information, Division of Health Care Financing, Department of Health and Family Services.

Table 30. Highest total charge-generating ambulatory surgical procedures, Wisconsin GMS hospitals and FASCs, 2002

ICD-9-CM Code	Procedure	Number of Cases	Average Charge	Total Charges
13.41	Phacoemulsification and Aspiration of Cataract	32,412	$3,680	$119,287,153
37.22	Left Heart Cardiac Catheterization	12,919	6,656	85,986,095
45.23	Colonoscopy	61,958	1,354	83,912,637
45.42	Endoscopic Polypectomy of Large Intestine	43,416	1,843	80,027,215
80.6	Excision of Semilunar Cartilage of Knee	14,684	4,884	71,723,202
51.23	Laparoscopic Cholecystectomy	9,702	7,292	70,750,462
45.16	Esophagogastroduodenoscopy (EGD) w/Closed Biopsy	40,148	1,710	68,659,578
13.59	Other Extracapsular Extraction of Lens	12,492	3,094	38,652,950
45.25	Endoscopic Biopsy of Large Intestine	19,563	1,751	34,262,383
85.21	Local Excision of Lesion of Breast	8,851	3,710	32,833,074
04.43	Carpal Tunnel Release	11,488	2,480	28,495,970
81.83	Other Repair of Shoulder	3,928	7,091	27,855,330
83.63	Rotator Cuff Repair	3,409	8,002	27,279,922
86.3	Local Excision/Destruction of Lesion or Tissue of Skin	20,468	1,260	25,799,540
81.45	Other Repair of the Cruciate Ligaments	2,527	9,918	25,062,860
03.92	Injection of other Agent into Spinal Canal	28,863	833	24,049,957
28.3	Tonsillectomy with Adenoidectomy	7,670	3,058	23,451,756
20.01	Myringotomy with Insertion of Tube	11,785	1,986	23,410,491
39.50	Angioplasty or Artherectomy of Non-Coronary Vessel	2,110	9,972	21,040,824
45.13	Other Endoscopy of Small Intestine	14,658	1,288	18,879,561

Note: Charges may reflect charges for other procedures performed during the same surgical episode

Source: Ambulatory Surgery Data, Bureau of Health Information, Division of Health Care Financing, Department of Health and Family Services.

Table 31. Ambulatory surgical procedures, by major category, Wisconsin GMS hospitals and FASCs, 2002

Category of Surgical Procedure	Number of Cases	Total Charges
Cardiovascular	31,806	$247,198,121
CPT Codes Not Converted	217	601,901
Diagnostic/Therapeutic	9,128	34,971,306
Digestive	259,214	560,807,221
Ear	16,428	43,903,811
Endocrine	2,164	6,887,514
Eye	69,302	226,268,098
Female Genital	29,009	115,992,440
Hemic/Lymphatic	4,174	14,367,589
Integumentary	65,608	155,101,846
Male Genital	9,622	26,737,200
Musculoskeletal	92,181	424,805,141
Nervous	76,708	111,579,199
Nose/Mouth/Pharynx	33,183	108,053,789
Obstetrical	4,824	2,945,902
Respiratory	8,603	24,099,727
Urinary	25,117	78,357,673
Statewide Totals	737,288	$2,182,678,477

Source: Ambulatory Surgery Data, Bureau of Health Information, Division of Health Care Financing, Department of Health and Family Services.

Caveats/Data Limitations for Ambulatory Surgery Data

1. The ambulatory surgery utilization and charge data in this report are drawn from the federal billing form HCFA-1450 (UB-92) and/or the federal billing form HCFA-1500 as submitted by 124 GMS hospitals and 33 FASCs. The charge data taken from these forms have not been audited. **As a result, the charge data provided in this report may differ from audited financial data.**
2. The reported payment sources are based on first billings rather than actual revenue sources. Therefore, the reported distribution of payment sources in this report may differ from the actual distribution of payments collected.
3. Utilization and charge figures of ambulatory surgery data were not adjusted for severity, case mix, or any of a variety of other factors that could affect comparisons among facilities. All interpretations of actual data and all comparisons of one facility to another should be made with caution. In addition to case mix and severity, regional pricing differentials and variations in the types of services offered can affect levels of utilization or charges. Also, facility record-keeping and internal information systems vary in their levels of sophistication. This may affect the quality of the data submitted by individual facilities.
4. Each facility was asked to list one principal procedure and up to five secondary procedures per record for each surgical episode.
5. The charges listed in the text and tables are for each record in the database, not for individual procedures. A case may include more than one procedure. For example, a woman having a breast biopsy may also have an excision of other breast tissue or lab and x-ray procedures. Since comparisons should be made only between patients undergoing the same combination of procedures, more detailed information is required to enable a full comparison between patients and facilities. In addition, differences in facility billing practices may affect the distribution of charges. For example, a selected follow-up procedure to cataract surgery may be reported to BHI either as part of the basic surgical episode or as a separate episode.
6. Charge data for individual facilities are not listed if fewer than five procedures were reported. However, the data are included in the statewide figures.
7. The charges that facilities report for outpatient procedures exclude professional fees.

Ambulatory Surgical Procedures Used in the Report

The report provides in-depth coverage of the following 20 procedures:

Carpal Tunnel Release - ICD-9-CM code 04.43; CPT-4 codes 29848 and 64721: the surgical relief of pressure of the median nerve at the wrist. It is commonly performed on persons whose jobs require frequent repetitive hand motions (e.g., typing).

Colonoscopy - ICD-9-CM code 45.23; CPT-4 code 45378: a diagnostic procedure performed on the large intestine, using flexible fiber optics (excludes flexible sigmoidoscopy).

Dilation of Esophagus - ICD-9-CM code 42.92; CPT-4 codes 43220, 43226, 43248, 43249, 43450, 43453, 43456, 43458, and 43510: the stretching increase in the size of the caliber of the esophagus.

Endoscopic Biopsy of Large Intestine – ICD-9-CM code 45.25; CPT-4 codes 44100, 44389, 45331, and 45380: the removal of living large intestine tissue for microscopic examination by a closed technique. Colonoscopy with biopsy. Excludes proctosigmoidoscopy with biopsy.

Endoscopic Polypectomy of Large Intestine - ICD-9-CM code 45.42; CPT-4 codes 44392, 44394, 45308, 45309, 45315, 45333, 45338, 45339, and 45385: the excision of large intestine polyp performed by an endoscopic technique.

Esophagogastroduodenoscopy (EGD) with Closed Biopsy - ICD-9-CM code 45.16; CPT-4 code 43239: biopsy of one or more sites involving the esophagus, stomach, and/or duodenum.

Excision of Semilunar Cartilage of Knee - ICD-9-CM code 80.6; CPT-4 codes 27332, 27333, 29880, and 29881: the cutting repair of a crescent-shaped portion of the knee joint cartilage. The procedure facilitates knee joint motion hampered by excess cartilage growth.

Flexible Sigmoidoscopy - ICD-9-CM code 45.24; CPT-4 code 45330: endoscopy of the descending colon.

Injection of Other Agent into Spinal Canal - ICD-9-CM code 03.92; CPT-4 codes 62288, 62289, 62298, and 96450: injection of a steroid drug or refrigerated saline into the subarachnoid space.

Injection of Spinal Canal for Analgesia - ICD-9-CM code 03.91; CPT-4 codes 62310, 62311, 62318, and 62319: injection of diagnostic or therapeutic substances including anesthetic, antispasmodic, optoid or steroid.

Laparoscopic Cholecystectomy - ICD-9-CM code 51.23; CPT-4 codes 56340-56342: the removal of the gallbladder performed by a laparoscopic technique.

Left Heart Cardiac Catheterization - ICD-9-CM code 37.22; CPT-4 codes 93510, 93511, and 93514: the insertion of a cardiac catheter into the left heart chambers for the detection or cardiac abnormalities.

Local Excision of Lesion of Breast - ICD-9-CM code 85.21; CPT-4 codes 19112, 19120, 19125, 19126, and 19371: the cutting removal of damaged breast tissue, includes lumpectomy.

Myringotomy with Insertion of Tube - ICD-9-CM code 20.01; CPT-4 codes 69433 and 69436: incision of the eardrum with insertion of a hollow tube for drainage.

Other Cystoscopy - *ICD-9-CM code 57.32; CPT-4 code 52000*: the optical instrumental examination of the bladder, other than through an artificial stoma.

Other Endoscopy of Small Intestine - ICD-9-CM code 45.13; CPT-4 codes 43235 and 43241: the optical instrumental examination of the small intestine, other than inserted through the abdominal wall or an artificial stoma.

Other Extracapsular Extraction of Lens - ICD-9-CM code 13.59; CPT-4 codes 66940 and 66984: removal of the lens of the eye, leaving the posterior capsule intact.

Other Local Excision or Destruction of Lesion of Skin and Subcutaneous Tissue - ICD-9-CM code 86.3; CPT-4 codes 11050-11052, 11200, 11201, 11300-11303, 11450, 11451, 11462,

11463, 11470, 11471, 15000, 17000-17002, 17010, 17100-17102, 17104-17108, 17110, 17200, 17201, 17250, 17260-17264, 17266, 17340, 21555, 23075, 24075, 25075, 26115, 27047, 27327, 27618, and 28043: the cutting removal or forcible death of damaged or other skin and subcutaneous tissue.

Phacoemulsification and Aspiration of Cataract - ICD-9-CM code 13.41; CPT-4 code 66850: removal of the lens of the eye, leaving the posterior capsule intact, using sound waves to liquefy the lens substance before withdrawal by suction.

Tonsillectomy with Adenoidectomy - ICD-9-CM code 28.3; CPT-4 codes 42820 and 43821: surgical removal of the tonsils and adenoids.

AMBULATORY SURGERY DATA TABLES

GMS Hospitals and FASCs by Selected Procedure: